Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL324952260M
Compliance #: HL324951300C

Date Concluded: April 23, 2024

Name, Address, and County of Licensee Investigated:
Serenity Living Solutions Remer
105 Spruce Street NW
Remer, MN 56672
Cass County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The facility neglected Resident #1 and Resident #2 when, due to a lack of supervision, Resident #1 assaulted Resident #2 after pulling him out of bed. The assault resulted in Resident #2 being transported to the hospital.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Resident #1 and Resident #2 had a prior resident-to-resident altercation and the facility failed to implement person centered interventions to prevent further incidents. Approximately three weeks later, the two residents had another altercation after Resident #2 wandered into Resident #1's room. Resident #1 assaulted Resident #2, resulting in Resident #2 being hospitalized.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted law enforcement, emergency

medical services staff, and hospice agency staff. The investigation included review of resident records, Resident #2's death record, hospital records, facility documentation, law enforcement reports, and related facility policies and procedures. At the time of the onsite visit, the investigator observed care and services at the facility.

Resident #1
Resident #1 resided in an assisted living facility. The resident's diagnoses included hypertension (high blood pressure) and type two diabetes. Resident #1's assessment indicated the resident had behaviors including physical and verbal aggression, as well as urinating in inappropriate places. The resident was noted to be physically abusive towards other residents with behaviors such as hitting, pushing, and stepping on feet. Staff interventions included using a friendly, calm approach, offering clear step-by-step cues and redirection, offering reassurance, listening to complaints/concerns/worries/fears, and to explain and remind the resident of appropriate behaviors.

Resident #2
Resident #2 also resided in an assisted living facility. The resident's diagnoses included late-onset Alzheimer's disease with behavioral disturbances and frontal lobe dementia. Resident #2's service plan indicated the resident received assistance with dressing, grooming, bathing, and behavior management. Resident #2's assessment indicated the resident was at risk to be abused and the resident required 24-hour supervision; staff were to observe for and remove the resident from potentially abusive/harmful situations. Resident #2 was noted to have a pattern of wandering behavior and staff were directed to "note wandering patterns, establish behavior patterns in the resident, re-direct and distract. Reassure resident. Offer activities, books, or TV." Resident #2 also had a history of physical aggression and was noted to push staff and other residents. The assessment indicated Resident #2 wandered with no purpose, and staff were to redirect the resident as able.

Facility documentation indicated approximately three weeks before Resident #2 was hospitalized, Resident #1 and Resident #2 had a resident-to-resident altercation after Resident #2 tried to take Resident #1's walker. Resident #1 hit Resident #2 in the face, causing a broken blood vessel in Resident #2's right eye. The facility failed to implement interventions to prevent further altercations other than "Spoke with this resident [Resident #1] and discussed not aggressive ways to solve conflict. Resident agreed to ask for staff assistance in the future." Three weeks after that incident, Resident #2 wandered into Resident #1's room. Resident #1 assaulted Resident #2, resulting in 911 being called.

The facility's internal investigation of the incident included a review of security camera footage which indicated Resident #2 wandered into Resident #1's room at 9:14 p.m. Resident #1 exited his room at 9:20 p.m., stood in the doorway, then went back in his room. At 9:37 p.m., Resident #1 left his room and called staff over to his room. Staff came to his room and left the room at 9:40 p.m. to call the on-call RN. 911 was called at 9:42 p.m.

The police report indicated police arrived at the facility at 9:51 p.m. in response to an alleged assault. The responding officer noted, "I learned that he [Resident #2] has late-stage dementia and had gone into the wrong room [Resident #1's room]. He [Resident #2] was lying in [Resident #1's] bed, so [Resident #1] pulled him out of the bed by his feet and struck him in the head. [Resident #2] had a black eye and some bleeding from his forehead. EMS crewmember sent me photos that she had taken when they first got into the room. [Resident #2] was lying on his side and there was blood on the floor by his head. I went inside and spoke with [unlicensed personnel] who led me to [Resident #1's] room. There was blood on the floor, on [Resident #1's] Crocs, and on a broken hairbrush. [Resident #1] admitted to pulling [Resident #2] out of his bed to [unlicensed personnel] prior to my arrival. Deputy was speaking with [Resident #1] in the hallway. [Resident #1] admitted to pulling [Resident #2] out of his bed and striking him with a brush."

Resident #2 died ten days after the incident and an autopsy is pending to determine the cause of death.

During investigative interviews, multiple unlicensed personnel (ULP) confirmed Resident #1 and Resident #2 had previous altercations leading up to the one that resulted in Resident #2’s hospitalization. ULP stated they encouraged Resident #1 to keep his door locked and they tried to keep an eye on Resident #2 to redirect him if he wandered into other resident’s rooms. ULP stated Resident #1 was told to alert staff if Resident #2 was bothering him, so they could redirect Resident #2.

During an interview, Resident #1 stated Resident #2 frequently came into his room and wandered around, went through his clothes, and played with his towels. Resident #1 stated, "Everything I have is all I've ever had, so I didn't want him touching it." Resident #1 stated the facility told him to lock his door to keep the resident out, but he did not like having his door locked and preferred it to be open. Resident #1 stated he had issues with Resident #2's wandering in the past and "I've walked away too many times, that's when I hit him."

During interviews with facility nursing and administrative staff, they stated they were aware of Resident #1 and Resident #2’s prior altercation(s) and confirmed specific interventions were not developed or implemented to prevent further occurrence.

During an interview, Resident #2’s power of attorney (POA) stated Resident #2 had a history of wandering and frequently went in and out of other resident’s rooms, but they were not aware of any specific interventions the facility put in place to keep him safe. The POA recalled that while visiting one day, a resident said, “this awful man lives here and comes in my room all the time.” The POA said they tried to explain that he [Resident #2] didn’t know what he was doing, but stated the residents did do not understand. The POA stated that after the first incident, the facility told them the resident fell and had a black eye and a cut lip. The POA said they were “utterly shocked” when they saw the resident. The POA stated that the resident could not see out of his eye at all; he did not fall, someone beat him up.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
“Neglect” means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: Resident #1- Yes
Resident #2 -No, due to cognitive impairment
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
Resident #1 was moved to a different facility.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Cass County Attorney
Remer City Attorney

Remer Police Department
Minnesota Board of Nursing-

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32495	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY LIVING SOLUTIONS REMER	105 SPRUCE STREET NW REMER, MN 56672

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: HL324959865M/ HL324957816C HL324952260M/HL324951300C On March 6, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 15 residents receiving services under the provider's Assisted Living license. The following correction order is issued for #HL324959865M/ HL324957816C, tag identification 2320. The following correction order is issued for #HL324952260M/HL324951300C, tag identification 0630, 2360.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 630 SS=J	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 1 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to assess and develop individualized interventions to ensure safety and prevent harm to others for two of two residents (R1, R2) after a resident-to-resident altercation occurred. Three weeks after R1 and R2 had a resident-to-resident altercation, another one occurred. R1 assaulted R2, resulting in R2 being hospitalized. R2 died ten days later. This practice resulted in a level four violation (a violation that results in serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 R1's diagnoses included hypertension (high blood pressure) and type two diabetes.	0 630		

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0 630	Continued From page 2 R1's assessment dated December 6, 2023, indicated R1 was forgetful at times and required reminders for certain tasks. R1 had behaviors including physical and verbal aggression, as well as urinating in inappropriate places. R1 was noted to be physically abusive to residents including hitting, pushing, and stepping on feet. Interventions included a friendly, calm approach, offering clear step by step cues and redirection, offering reassurance, listening to complaints/concerns/worries/fears, and explain and remind of appropriate behavior. The assessment identified R1 was provided 24 hour supervision and staff will observe for and remove the resident from potentially abusive/harmful situations. R1's progress notes included the following: -On February 7, 2024, R1 "hit another resident [R2] in the face causing a broken blood vessel in the other resident's right eye. Spoke with [R1] and discussed not aggressive ways to solve conflict. [R1] agreed to ask for staff assistance in the future. RN & PCP updated to incident." An incident report completed after the altercation indicated R2 had attempted to hang on to [R1]'s walker and R1 tried to hang on to the walker to keep R2 from taking it. "That was not working so [R1] stood up and hit [R2] in the face on the right side. [R2] let go of the walker. Additional actions recommended included "resident agreed to notify staff in the future instead of acting out physically." -On February 8, 2024, clinical nurse supervisor (CNS)-F documented "[R1] agreed to notify staff in the future instead of acting out physically towards other residents." -On February 13, 2024, the facility was notified by a neighboring county's sheriff's office that [R1] had an outstanding warrant for his arrest. -On February 15, 2024, the facility was advised	0 630		

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0 630	Continued From page 3 by the sheriff's office of next steps to resolve the warrant since [R1] had not been involved in illegal drugs/activity since admission to the facility. R1's assessment dated February 8, 2024, indicated R1 was at risk to abuse other vulnerable adults after he physically hit another resident. The intervention noted "resident agreed to notify staff in the future instead of acting out physically." Staff provide 24-hour supervision and would "observe for and remove resident from potentially abusive/harmful situations." The assessment indicated R1 was forgetful at times and required reminders for certain tasks. R1 had behaviors including physical and verbal aggression, as well as urinating in inappropriate places. R1 was noted to be physically abusive to residents including hitting, pushing, and stepping on feet. Interventions included a friendly, calm approach, offering clear step by step cues and redirection, offering reassurance, listening to complaints/concerns/worries/fears, and explain and remind of appropriate behavior. R2 R2's diagnoses included late-onset Alzheimer's disease with behavioral disturbances and frontal lobe dementia. R2's service plan dated February 6, 2024, indicated the resident received assistance with dressing, grooming, bathing, and behavior management. R2's February 22, 2024, assessment indicated R2 was at risk to be abused and the resident required 24 hour supervision where staff would observe for and remove resident from potentially abusive/harmful situations. R2 was noted to have behaviors including wandering. Staff were to	0 630		

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0 630	Continued From page 4 "note wandering patterns, establish behavior patterns in the resident, re-direct and distract. Reassure resident. Offer activities, books, or TV." The resident had a history of being physically aggressive to staff and residents by pushing. The assessment indicated the resident would "wander with no purpose, staff is to redirect as able." R2's assessment or individual abuse prevention plan (IAPP) lacked mention of the February 7, 2024, incident with R1. R2's progress notes included the following: -On December 4, 2023, "It is noted that [R2] has bruising under his right eye and above right eyebrow. Also scabbed area under right eye. This was not present on Friday when writer left. Current staff on site were unsure of what had happened. Upon further investigation it is discovered that another resident had punch this resident in the face for trying to take food from his plate during supper on 12/2. On call RN and AL Director had been notified of incident. Staff were able to separate two residents without further incident. Hospice case manager and family updated following discovery of the incident. -January 1, 2024, No changes in mobility per staff. Walks often through out facility and wanders into other resident rooms. Continue with current care plan. -January 9, 2024, [R2] is noted to have a bruise under his left eye that is of unknown origin. Resident is noted to be rubbing eyes often today. Call placed to spouse to update. Voicemail left for her to call the facility. -February 7, 2024, [R2] sustained a broken blood vessel in his right eye following an incident with another resident [R1]. Resident was easily guided away from the area. Manager, RN and PCP & Hospice updated to the incident. Call placed to resident's wife/guardian to update.	0 630		

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0 630	Continued From page 5 An incident report completed after the altercation indicated R2 attempted to hang on to [R1]'s walker and R1 tried to hang on to the walker to keep R2 from taking it. "That was not working so [R1] stood up and hit [R2] in the face on the right side. [R2] let go of the walker. Additional actions recommended included "[R1] agreed to notify staff in the future instead of acting out physically." The RN failed to identify interventions to keep R2 safe or prevent recurring resident-to-resident altercations. A progress note dated February 25, 2024, indicated R2 was taken to the emergency room "after being found in his room with injuries to the face. Staff report discoloration and swelling around the eyes and blood coming from his mouth possibly from biting his tongue." A police report dated February 25, 2024, indicated police arrived at the facility at 9:51 p.m. for an alleged assault. The responding officer noted, "I learned that he has late stage dementia and had gone into the wrong room [R1's room]. He was lying in [R1's] bed, so [R1] pulled him out of the bed by his feet and struck him in the head. [R2] had a black eye and some bleeding from his forehead. EMS crewmember sent me photos that she had taken when they first got into the room. [R2] was lying on his side and there was blood on the floor by his head. I went inside and spoke with [unlicensed personnel] led me to [R1's] room. There was blood on the floor, on [R1's] Crocs, and on a broken hairbrush. [R1] had admitted to pulling [R2] out of his bed to [unlicensed personnel] prior to my arrival. Deputy was speaking with [R1] in the hallway. [R1] admitted to pulling [R2] out of his bed and striking him with a brush."	0 630		

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0 630	Continued From page 6 The facility's internal investigation indicated R2 wandered into R1's room at 9:14 p.m. R1 exited his room at 9:20 p.m., stood in the doorway and then went back in his room. At 9:37 p.m., R1 left his room and called staff over to his room. Staff came to his room and left the room at 9:40 p.m. to call the on-call RN. 911 was called at 9:42 p.m. On March 6, 2024, at 9:30 a.m., the investigator observed R2 laying in bed in his room. R2's face had scattered bruising with a black right eye. On March 6, 2024, at 10:25 a.m., unlicensed personnel (ULP)-A stated R1 was "kinda protecting his territory. [R2] does not understand where or what he's doing, so we try to make sure all the doors are locked since [R2] will wiggle the door handle and then move on." ULP-A stated interventions included monitoring R2 and redirecting him if he started to wander into other resident rooms. On March 6, 2024, at 10:35 a.m., ULP-B stated she was "not surprised" when she heard about R1 and R2's altercation because "we have another resident that messes with doors and gets on other resident's nerves and he [R1] has made comments like "I'm gonna have to teach him a lesson" and other little things like that; [R1] showed signs of aggression but I never heard him say anything about [R2]...but I can't say I was surprised." On March 6, 2024, at 10:45 a.m., ULP-C stated R1 and R2 had prior altercations. ULP-C stated interventions included having R1 lock his door and redirecting R2 away from R1 if he was wandering. ULP-C stated R1 didn't always want to lock his door.	0 630		

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0 630	Continued From page 7 On March 6, 2024, at 10:55 a.m., licensed practical nurse (LPN)-D stated R1 and R2 had a "couple of minor altercations". LPN-D stated they talked to R1 after the altercations and told him that's not the proper way to handle those types of situations and since R1 expressed remorse, they felt it had been addressed and he would not do it again. LPN-D stated interventions for R2 included "being more diligent on knowing his whereabouts and keeping them [R1 and R2] separated", and to redirect R2 if there was any tension or it seemed he was too close to R1. LPN-D was asked if the interventions put in place were sufficient and reduced the risk of future altercations. LPN-D stated, "I mean, we tried our best to distract him [R2], but can't always control his choices either. We did our best to keep eyes on him [R2] and tried if we saw him going down that way [toward R1's room], to see if we could get him to come up to do activities or have a snack or anything to change his thought process. For the most part, it was successful if we caught him [R2] prior to bothering [R1]." LPN-D stated the facility had tried other interventions like telling R1 to lock his door if he didn't want R2 coming in his room or putting a stop sign on R1's door; however, R1 did not want to keep his door locked or have anything on his door. On March 6, 2024, at 11:20 a.m., licensed assisted living director (LALD)-E stated R1 and R2 had prior altercations. LALD-E stated R1 sometimes kept his door locked but sometimes he'd want to leave it open and told staff he didn't want to have to lock his door all the time. LALD-E stated he told R1 that a wandering resident could enter his room and he [R1] understood it and said he sometimes liked the visitors. LALD-E stated interventions for R1 included notifying staff if R2	0 630		

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0 630	Continued From page 8 wandered in his room and keeping the door to his room locked. LALD-E stated they asked R1 if he wanted a stop sign on his door and he declined. On March 8, 2024, at 10:00 a.m., R1 stated R2 frequently came into his room and wandered around. R2 went through his clothes, and played with his towels. R1 stated, "Everything I have is all I've ever had, so I didn't want him touching it." R1 stated the facility told him to lock his door to keep R2 out, but he did not like having his door locked and would rather it be open. R1 stated he had issues with R2's wandering in the past and "I've walked away too many times, that's when I hit him." R1 added, "He kinda fell and hit his head, his ear was bleeding." On March 8, 2024, at 10:20 a.m., R1's power of attorney (POA)-I stated "[R2] didn't know, he would wander into rooms and when I was visiting one day, I had one resident tell me "this awful man lives here comes in my room all the time". I said "oh, he's my husband. He doesn't know what he's doing" but people don't understand that. After the incident, when we walked in the door we were utterly shocked. He did not fall, someone beat him. We thought he fell, that's what they told us; he fell and has a black eye and a cut lip, but that is not what I found. He couldn't see out of his eye at all. I paid $8,800 a month to keep him safe it didn't happen." On March 8, 2024, at 12:45 p.m., clinical nurse supervisor (CNS)-F confirmed R1 and R2's IAPP's lacked specific interventions to reduce the risk of additional resident-to-resident altercations. CNS-F was asked if other interventions related to R1's history of aggression should have been in place and CNS-F stated R1 had previously been homeless and he was "probably protecting his	0 630		

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	32495	A. BUILDING: _____ B. WING _____	C 03/06/2024

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0 630	Continued From page 9 stuff and his area, that could have played into his background as to why he was so protective." CNS-F confirmed that information about the resident's past and that being a vulnerability was not identified in any of his assessments. CNS-F stated after the February 25, 2024, incident they had talked about "why would someone do this, are we sure he won't do it to someone else? We felt confident he wouldn't. This was someone going in his space and wandering. I think it is in there [R1's assessment] that he had a history of physical or verbal aggression but there was nothing to say he's going to attack someone." CNS-F was asked if there should have been more interventions in place after the February 7, 2024, incident between R1 and R2 to prevent the incident that resulted in R2's hospitalization. CNS-F stated, "Well, I feel like that's maybe unfair to say because I feel like no one predicted what happened...I don't know if you could have care planned a way, that wouldn't have changed this outcome necessarily...I don't feel like none of us knew he was going to do this." CNS-F stated the interventions in place were sufficient and "if [R1] wanted a staff member [after R2 entered his room on February 25, 2024], he could have found one. He chose to do what he did...even if he couldn't find a staff member, it isn't our fault he [R1] went in and did what he did." R2 died the evening of March 6, 2024. At the time of this report, an autopsy was pending to determine the cause of death. The licensee's Individual Abuse Prevention Plan policy, dated August 1, 2021, indicated the IAPP would contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults and the person's risk of abusing	0 630		

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0 630	Continued From page 10 other vulnerable adults, No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide care and services in accordance with the service plan, when staff failed to administer medications as ordered, resulting in medication error for one of one resident (R3) reviewed. The registered nurse (RN) failed to discontinue an order for an opioid narcotic, Percocet, and continued giving the medication for 24 days until the resident was hospitalized for a change in condition. In addition, medication errors occured after staff marked medication as given when it was not. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and	02320		

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02320	Continued From page 11 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R3's diagnoses included acute ischemic stroke (a blockage that keeps blood from reaching all areas of the brain, resulting in brain damage) and encephalomalacia (the softening or loss of brain tissue after a stroke or other injury.) R3's service plan dated indicated the resident received services including medication administration. R3's assessment dated November 16, 2023, indicated the facility was responsible for medication management including implementing new orders. The resident was noted to have visual and cognitive impairment and chronic back pain. R3's progress notes indicated the resident saw his primary care provider (PCP)-H on November 13, 2023, and received new orders to discontinue his percocet (Oxycodone-APAP 10-325 mg) and start Oxycontin 10 mg by mouth every 12 hours. R3's prescriber orders dated November 13, 2023, indicated percocet (Oxycodone-APAP 10-325 mg) was to be discontinued and to start Oxycontin 10 mg every 12 hours. R3's record contained a fax from LPN-D to PCP-H dated December 5, 2023, at 9:50 a.m., which read, "I will be sending a refill for [R3's] Oxycodone as we still have not received the Oxycontin. Last update from pharmacy was there	02320		

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02320	Continued From page 12 was a preauthorization in process..." R3's progress notes indicated the resident received new medication orders on December 5, 2023. A facility on-call registered nurse, (RN)-G documented the resident's oxycontin (an opioid pain medication) was discontinued, oxycodone (Percocet) was on hold, and the resident was started on Xtampza ER (an opioid pain medication) 9 milligrams (mg) twice daily. Progress notes indicated oxycodone/APAP 10-325 mg was destroyed on December 6, 2023, at 5:55 p.m. R3's prescriber orders dated December 5, 2023, indicated Oxycontin was to be discontinued, discontinue percocet, and start Xtampta 9 mg twice daily. On December 7, 2023, the resident's provider was contacted regarding "altered mental status, disorientation, disorganized motor skills, new incontenence, and increased weakenss. New orders received from NP [nurse practitioner] to DC [discontinue] Xtampza ER and restart previous Oxycodone/APAP 10/325. RX [prescription] copy received from pharmacy. Resident updated to changes being made to medication and agreeable. Staff instructed to do frequent checks on resident to ensure his safety and well being. RN updated to change in resident and new orders." R3's prescriber orders dated December 7, 2023, indicated to stop the Xtampza and resume prior Oxycodone orders. R3's December 2023 medication administration record (MAR) contained the following: -December 5:	02320		

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02320	Continued From page 13 -Xtampza 9 mg was administered at 8:55 a.m -Oxycontin 10 mg was administered at 8:55 a.m. -Oxycodone-APAP 10-325 mg was administered at 8:55 a.m. -Xtampza 9 mg was administered at 8:55 p.m. -December 6: -Xtampza 9 mg was administered at 7:42 a.m. -Oxycodone-APAP 10-325 mg was administered at 7:42 a.m. -Xtampza 9 mg was administered at 8:10 p.m. -December 7: -Xtampza 9 mg was administered at 9:18 a.m. -Oxycodone-APAP 10-325 mg was administered at 8:10 p.m. -December 8: -Oxycodone-APAP 10-325 mg was administered at 8:57 a.m. -Oxycodone-APAP 10-325 mg was administered at 9:04 p.m. Narcotic count records provided for Oxycodone-APAP 10-325 mg for the time period from December 4, 2023, through December 8, 2023, indicated Oxycodone-APAP was only administered on December 5, 2023, at 8:49 a.m., indicating the December 6, 2023, administration was documented as given but not actually administered. The remaining ten pills were destroyed on December 6, 2023, at 10:10 a.m. A second card of the medication indicated Oxycodone-APAP was administered again on December 7, 2023, at 8:42 p.m., and December 8, 2023, at 8:34 a.m. and 8:38 p.m. Narcotic count records provided for Xtampza ER	02320		

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02320	Continued From page 14 9 mg for the time period of December 5, 2023, through December 8, 2023, indicated the first dose was given on December 5, 2023, at 8:49 p.m., indicating the 8:55 a.m. administration was documented as given but not actually administered. The Xtampza ER was destroyed on December 7, 2023, at 3:11 p.m. R3's November 2023 MAR lacked the Oxycontin 10 mg order. R3's December 2023 MAR indicated the resident received Oxycontin 10 mg twice daily however only appeared on the MAR once to be given at 8:30 a.m. December 1, 2, 3, and 4, were blank with no documentation indicating it was administered. The Oxycontin 10 mg was documented as administered on December 5, 2023, and the order was discontinued on December 6, 2023. Facility records did not include narcotic count records, as the Oxycontin was never received. On December 8, 2023, at 11:16 p.m., the on-call Registered Nurse [(RN)-G] was called and updated the "resident is not interacting with them as he has he normally does. He reported vitals are a resp [respirations] 14, pulse 79, blood pressure approximately 120/90 and he is sleeping upright at 45 degrees in his recliner, extremeties are warm to the touch and he has reflex when moving him around. Set up vitals for every one hour and to call back with poor vitals." Staff called back at 11:46 p.m. "reporting declining resp [respirations] and continues to not respond well when staff try to arouse. Instructed staff to call 911." The ambulance report indicated emergency	02320		

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02320	Continued From page 15 medical services were called at 11:48 p.m. on December 8, 2023 for an unconscious resident. The report indicated the resident "fell approximately two weeks ago per staff. Bruising on right eye, left chest, scarred abrasion to right leg. Staff went in to prepare for bed and patient was unresponsive...patient did not really respond verbally to questions, except to shake head to a question..." The resident was transported to the hospital. An incident report dated December 8, 2023, at 11:00 p.m. indicated 911 was called after staff "walked into his room and tried to move him. I got zero responds (sic) from resident and had sent some staff in room to try get a responds (sic) and get vitals and called 911 soon after." On March 6, 2024, at 10:10 a.m., LPN-D stated she had not previously reviewed R3's MAR and was not aware of the discrespencies on medications given. LPN-D stated the resident's Oxycontin was never able to be filled due to needing a prior authorization and an order to discontinue the medication was not obtained until December 5, 2023, 22 days after it was initially prescribed. On March 7, 2024, at 1:40 p.m., the resident's primary care provider (PCP)-H stated the resident should not have been receiving opioid pain medication while taking Xtampza, as the Oxycodone would be a short acting medication where the Xtampza was a long acting medication. PCP-H stated, "We'd never want anyone taking those together, it's the same medication just a little different." PCP-H stated the Percocet/Oxycodone-APAP 10-325 should have been discontinued in November and he should not have been taking it after that.	02320		

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02320	Continued From page 16 Prescribing information for Xtampza ER dated November 2016, indicated "serious, life-threatening, or fatal respiratory depression may occur with use of XTAMPZA ER. Monitor for respiratory depression, especially during initiation of XTAMPZA ER... XTAMPZA ER is administered, twice daily, every 12 hours, and must be taken with food. Discontinue all other around-the-clock opioid drugs when XTAMPZA ER therapy is initiated." Other side effects included extreme dizziness, weakness, shallow breathing, and sleepiness. The licensee's Medication & Treatment Orders-Implementing policy dated August 1, 2021, indicated medication orders received by the facility must be implemented within 24 hours of receipt. The licensee's Medication Error policy dated August 1, 2021, indicated "for the safety of the residents, the facility has a goal of zero medication errors. In the event an error occurs, staff will document, track, and resolve medication administration errors for quality improvement." Staff would be retrained if necessary. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.	02360		

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02360	Continued From page 17 This MN Requirement is not met as evidenced by: The facility failed to ensure two of two residents reviewed (R1, R2) were free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	